INSURANCE
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD
Small Employer Health Benefits Program

Adopted Repeal: N.J.A.C. 11:21 Appendix Exhibits J and AA

Adopted Repeals and New Rules: N.J.A.C. 11:21-3.2(c)1 and 2 and Appendix Exhibit H

Proposed: February 4, 2002 at 34 NJR 2(1).

Filed: _____ as R. 2002 d. ____ with technical changes not requiring additional notice and comment (see N.J.A.C. 1:30-4.8).

Authorized By: New Jersey Small Employer Health Benefits Program Board, Wardell Sanders, Executive Director.

Authority: N.J.S.A. 17B:27A-17 et seq.

Effective Date: January 21, 2003

Operative Date: June 1, 2003

Expiration Date:

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Small Employer Health Benefits ("SEH") Program Board held a hearing on Wednesday, March 20, 2002 at 1:00 P.M. at the Department of Banking and Insurance, Room 218, 20 West State Street, Trenton, New Jersey to receive testimony with respect to the proposed amendments, repeals and new rules to the standard health benefits plan set forth in N.J.A.C. 11:21 as Appendix Exhibits A, F, G, N, O, V, W, Y, BB, HH, II, H, I, J, K, Z, AA and JJ. Ellen DeRosa served as hearing officer. Although a number of persons offered comments regarding certain provisions contained in Appendix Exhibits F, G, W, Y, HH and II, no oral comments on proposed repeal of Appendix Exhibits H, I, J, Z and AA or new Appendix Exhibit H were received. The hearing officer made no recommendations regarding the proposed repeal of Appendix Exhibits H,

I, J, Z and AA or new Appendix Exhibit H. Written comments were received from a number of persons and entities as regards the entire proposal. With respect to that section of the proposal that the SEH Board is taking action to adopt, written comments were received from: Horizon Blue Cross Blue Shield of New Jersey, Oxford Health Plans, The ARC of Essex County, The ARC of Salem County, The ARC of New Jersey (two letters), The ARC of Union County, The ARC of Bergen and Passaic Counties, The ARC of Monmouth, and two consumers, Lani Walvick and Carolyn Hayer. The record of the public hearing may be reviewed by contacting Ellen DeRosa, Deputy Executive Director, SEH Board, PO Box 325, Trenton, NJ 08625-0325.

Regarding the comments the Board received on the remainder of the proposal, the Board intends to re-propose the regulation and appendix exhibits and will address all of the remaining comments at that time. In addition, the Board will address legislation that was passed since the proposal was first filed.

Summary of Public Comments and Agency Responses:

COMMENT 1: Horizon Blue Cross Blue Shield of New Jersey suggested that the Audit Procedures section in the prescription drug rider (Exhibit H) should be made variable. The Commenter stated that carriers are not required to perform audits on pharmacies.

RESPONSE 1: The Board agrees with the Commenter's suggestion that the Audit Procedures section in the prescription drug rider as set forth in Exhibit H be made variable. The Audit Procedures section has been enclosed in brackets to reflect the variable nature of the section.

COMMENT 2: Horizon Blue Cross Blue Shield of New Jersey suggested that additional text be added to the Other Charges section of the prescription drug rider that addresses

the nature of the charges and disclosure regarding the charges. Specifically, the Commenter suggested that the following text be added: "provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and purchaser's out-of-pocket cost for those services have been disclosed to the [Covered Person] prior to dispensing the drug".

RESPONSE 2: The Board agrees with the Commenter's suggested additional language and has added the text to the Other Charges section of the prescription drug rider as set forth as Exhibit H. The Board notes that the additional text is consistent with language in N.J.S.A. 17B:27-46.1i.

COMMENT 3: Oxford Health Plans asked how, under the prescription drug rider proposed as Appendix Exhibit H, a determination will be made as to which drugs require preapproval and further asked whether supplies needed to administer a prescription would include diabetic supplies.

RESPONSE 3: The Board is not establishing a list of drugs for which pre-approval is required. Each carrier must establish a list of drugs for which it will require pre-approval. The Board notes that it included variable language regarding pre-approval in Appendix Exhibit H in response to carrier requests for such flexibility. Based on discussions with the New Jersey Department of Banking and Insurance, it is the Board's understanding that carrier pre-approval lists shall contain no more than a dozen drugs. The text regarding coverage for supplies to administer prescription drugs was proposed to be included in the plans to which the prescription drug rider would be attached, not in the prescription drug rider. However, to answer the commenter's question regarding coverage for diabetic supplies, the Board notes that prescription diabetic supplies are

covered under the standard plans, but the Board does not dictate whether they must be covered as a prescription drug benefit or as a medical plan benefit. Carriers may elect to provide that coverage under the medical plan or under a prescription drug rider.

COMMENT 4: The numerous letters from various county and state organizations of The ARC contain substantially identical comments. The commenters expressed concern with allowing carriers to apply formulary restrictions and pre-approval requirements in the standard small employer plans. The commenters noted that persons with chronic medical or mental problems often require multiple medications. Three commenters noted side effects of some medications and indicated that certain brand name drugs could be more appropriate than others for treating a condition.

RESPONSE 4: The Board appreciates the concerns raised by the commenters. The Board believes that the provisions allowing use of formularies and pre-approval have been crafted to offer necessary protection for consumers. First, the rider, as proposed, only allows carriers to use an open formulary. This means that all FDA-approved drugs must be covered, but that cost sharing provisions can differ for generic, versus preferred, versus non-preferred drugs. However, if the consumer's doctor can demonstrate that a non-preferred drug meets the approval standard set forth in the rider and that all of the preferred drugs have been ineffective or caused or are expected to cause harmful reactions, then the non-preferred drugs will be covered subject to the same cost sharing as a preferred drug. The rider contains an appeals process in the event a request is denied. Regarding pre-approval, carriers are required to provide advance notice regarding which drugs require pre-approval and are required to arrange for a 96-hour supply of the drugs to be dispensed when the pre-approval review is taking place. There is an appeals

mechanism that may be followed if preapproval is denied. The formulary and pre-approval provisions were included in the rider to allow carriers to encourage use of drugs that are the most appropriate and most cost-effective. It was not the intention of the Board that persons would be denied coverage for medically necessary and appropriate medications.

COMMENT 5: The two consumer commenters raised concerns with the use of a formulary in the standard prescription drug rider. The commenters seem to indicate that the use of a formulary will restrict what medications doctors can prescribe. They oppose such restrictions being imposed on the prescriptions that can be received.

RESPONSE 5: The Board thanks the commenters for their comments and takes this opportunity to explain that the use of a formulary is not a mechanism that restricts the medications a doctor may prescribe. The rider in no way restricts the medications that may be prescribed nor does it prohibit a consumer from securing coverage for any specific medication. The use of preferred and non-preferred drugs is to make a distinction in terms of the cost sharing the consumer must pay when purchasing a preferred or a non-preferred drug. The cost sharing is generally less for preferred drugs. The standard prescription drug rider does not permit a closed formulary which would provide no coverage for drugs not considered to be preferred drugs. Since the rider will provide coverage for all drugs, whether they are preferred or non-preferred, the formulary is considered to be an open formulary. An open formulary does not permit the type of restrictions with which the commenters expressed concern.

Agency Initiated Changes

The Board is correcting the punctuation in N.J.A.C. 11:21-3.2(c)1 and 2.

Federal Standards Statement

The standard individual health benefits plans comply with the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191. The standard plans, and the rules describing the standard plans, do not expand upon the requirements set forth in the Federal law.

Full text of the adoption follows (additions indicated in boldface *thus*; deletions indicated in cursive brackets *{thus}*):

11:21-3.2 Optional benefit riders to standard plans and administrative functions

(a) – (b) no change

(c) The standard optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select the following rider, set forth at Exhibit H, to be offered with each health benefits Plan (Plan B, C, D or E)***[:]* *;and***

2. Replacement prescription drug benefits for the HMO Plan or the HMO POS Plan. The carrier may select one or more of the following riders, set forth at Exhibit H, to be offered with the HMO or HMO POS health benefits plan***[:]* *.***

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Wardell Sanders, Executive Director

Date: December 12, 2002